Per Diem Rates: Rates paid to ICF/MRs under the Nebraska Medical Assistance Program. The rates are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities to provide services in conformance with state and federal laws, regulations, and quality and safety standards.

Consumer Price Index (CPI): Whenever used in this section, CPI is the Consumer Price Index, All Urban Consumers, Average for all United States Cities, as determined by the U.S. Department of Labor, Bureau of Labor Statistics.

Other definitions which apply in this section are included in Nebraska Department of Health's Regulations and Standards for Homes for the Aged or Infirm, Regulations and Standards Governing Centers for the Developmentally Disabled, and appropriate federal regulations governing Title XIX and Title XVIII.

31-008.03 General Information: Wherever applicable, the principles of reimbursement for provider's cost and the related policies under which the Medicare extended care facility program functions (Medicare's Provider Reimbursement Manual (HIM-15) updated by "Provider Reimbursement Manual Revisions" in effect as July 1, 1991) are used in determining the cost for Nebraska ICF/MR's with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety. That portion of a provider's allowable cost for the treatment of Medicaid patients is payable under the Nebraska Medical Assistance Program (NMAP) except as limited in this section. Because Title XVIII principles of reimbursement are further restricted by these regulations, the aggregate payments by the Department do not exceed amounts which would be paid under Title XVIII principles of reimbursement for extended care facilities.

31-008.04 Allowable Costs: The following items are allowable costs under NMAP.

31-008.04A Cost of Meeting Licensure and Certification Standards: Allowable costs for meeting licensure and certification standards are those costs incurred in order to -

1. Meet the definition in 42 CFR 440.150;
2. Comply with the standards prescribed by the Secretary of Health and Human Services (HHS) in 42 CFR 442;
3. Comply with requirements established by the Nebraska Department of Health, the state agency responsible for establishing and maintaining health standards, under 42 CFR 431.610; and
4. Comply with any other state law licensing requirements necessary for providing skilled nursing or intermediate care facility, as applicable.

31-008.04B Items Included in Per Diem Rates: The following items are included in the per diem rate:

1. Routine Services: Routine ICF\MR services include regular room, dietary, and nursing services; social services and active treatment program as required by certification standards; minor medical supplies; oxygen; the use of equipment and facilities; and other routine services. Examples of items that routine services may include are -
   a. All general nursing services, including administration of oxygen and related medications; collection of all laboratory specimens as ordered by the physician, such as: blood, urine; handfeeding; incontinency care; tray service; normal personal hygiene which includes bathing, skin care, hair care (excluding professional barber and beauty services), nail care, shaving, and oral hygiene; enema; etc.;

b. Active treatment: The facility shall provide a continuous active treatment program as determined necessary by each client's Interdisciplinary team; including physical therapy, occupational therapy, speech therapy, recreational therapy, and pre-vocational services as described in each client's Individual Plan of Care (see 42 CFR 483.440 and 471 NAC 31-001.02);

c. Items which are furnished routinely and relatively uniformly to all patients, such as patient gowns, linens, water pitchers, basins, bedpans, etc.;

d. Items stocked at nursing stations or on each floor in gross supply and distributed or used individually, such as alcohol, applicators, cotton balls, bandaids, incontinency care products, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, I.V. equipment, T.E.D. (anti-embolism) stockings, hydrogen peroxide, O-T-C enemas, tests (Clinitest, Testape, Ketostix), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (which includes soap, moisturing lotion, powder, shampoo, deodorant, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, denture adhesive, dental floss, tooth-brushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, sanitary napkins and related supplies, etc.), etc.;

e. Items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, gerichairs, traction equipment, alternating pressure pad and pump, other durable medical equipment, etc.;

f. Special dietary supplements used for tube feeding or oral feeding, such as an elemental high nitrogen diet, even if written as a prescription item by a physician. These supplements have been classified by the Food and Drug Administration as a food rather than a drug; and

g. Laundry services, including personal clothing.

2. Injections: The patient's physician shall prescribe all injections. Payment is not authorized for the administration of injections, since giving injections is considered a part of routine nursing care and covered by the long term care facility's reimbursement. Payment is authorized to the drug provider for drugs used in approved injections. Syringes and needles are necessary medical supplies and are included in the per diem rate.

3. Transportation: The facility is responsible for ensuring that all clients receive appropriate medical care. The facility shall provide transportation to client services that are reimbursed by Medicaid (i.e., physician, dental, etc.). The reasonable cost of maintaining and operating a vehicle for patient transportation is an allowable cost and is reimbursable under the long term care reimbursement plan.

31-008.04C Ancillary Services: Ancillary services are those services which are either provided by or purchased by an ICF/MR and are not properly classified as "routine services." The ICF/MR shall contract for ancillary services not readily available in the ICF/MR.

If ancillary services are provided by a licensed provider, e.g., physician, dentist, etc., the provider shall submit a separate claim for each client served.

Occupational therapy, physical therapy, speech pathology, audiology, psychological, and resident transportation services are considered routine operating costs for intermediate care for the mentally retarded.

Department-required independent QMRP assessments are considered ancillary services.

31-008.04D Items Not Included in the Per Diem Rates: Any cost paid by the Department directly to another provider is not an allowable cost in determining the per diem rate. Items for which payment may be authorized to non-Nursing Facility or ICF/MR providers and are not considered part of the facility's Medicaid per diem are listed below. These items are not included in the per diem rates. The Department makes payment directly to the provider of service as specified in Attachment 4.19-B of the Plan. To be covered, the client's condition must meet the criteria for coverage for the item as outlined in the appropriate Medicaid provider chapter. The provider of the service may be required to request prior authorization of payment for the service.

1. Legend drugs, OTC drugs*, and compounded prescriptions, including intravenous solutions and dilutants (see Limitations to Attachment 3.1-A, Items 12c and 12d and Attachment 4.19-B, Items 12c and 12d). *Note: Bulk supply OTC drugs may be provided by the facility in accordance with physician orders and then become an allowable cost on the facility's cost report;
2. Personal appliances and devices, if recommended in writing by a physician, such as eye glasses, hearing aids, etc. (see Limitations to Attachment 3.1-A, Items 12c and 12d and Attachment 4.19-B, Items 12c and 12d);
3. Wheelchairs are considered necessary equipment in an ICF/MR to provide care. Non-standard wheelchairs, including power-operated vehicles, and wheelchair seating systems, including certain pressure reducing wheelchair cushions, needed for the client's permanent and full time use may be approved (see Limitations to Attachment 3.1-A, Item 7c and and Attachment 4.19-B, Item 7c);
4. Air fluidized bed units and low air loss bed units (see Limitations to Attachment 3.1-A, Item 7c and and Attachment 4.19-B, Item 7c);
5. Augmentative communication devices/accessories (see Limitations to Attachment 3.1-A, Item 7c and and Attachment 4.19-B, Item 7c);

6. Supports (elastic stockings, trusses, etc.) as defined in Limitations to Attachment 3.1-A, Item 7c and Attachment 4.19-B, Item 7c) excluding surgical/anti-embolism stockings;
7. Orthoses (lower and upper limb, foot and spinal) as defined in Limitations to Attachment 3.1-A, Item 7c and Attachment 4.19-B, Item 7c);
8. Prostheses (breast, eye, lower and upper limb) as defined in Limitations to Attachment 3.1-A, Item 7c and Attachment 4.19-B, Item 7c);
9. Oxygen and oxygen equipment (see Limitations to Attachment 3.1-A, Item 7c and Attachment 4.19-B, Item 7c), if the client's prescribed need for oxygen meets the minimum liters per minute (LPM) and hours per day as outlined below:

LPM	Minimum Hours Per Day
1.5	24
2	14
2.5	12
3	10
3.5	9
4	8
4.5	7
5	6

10. Repair of medically necessary, client-owned durable medical equipment otherwise covered for clients residing in Nursing Facilities and ICF/MR's (see Limitations to Attachment 3.1-A, Item 7c and Attachment 4.19-B, Item 7c);
11. Parenteral nutrition solution and additives (see Limitations to Attachment 3.1-A, Item 7c and Attachment 4.19-B, Item 7c);
12. Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care which meet the definitions in Limitations to Attachment 3.1-A, Item 24a and Attachment 4.19-B, Item 24a).
    a. To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client's health, whether or not such other transportation is actually available, NMAP shall not make payment for ambulance service.
    b. Non-emergency ambulance transports to a physician/practitioner's office, clinic, or therapy center are covered when the client is bed confined before, during and after transport AND when the services cannot or cannot reasonably be expected to be provided at the client's residence (including the ICF/MR).

31-008.05 Unallowable Costs: The following costs are specifically unallowable:

1. Provisions for income tax;
2. Fees paid board of directors;
3. Non-working officers' salaries;
4. Promotion expenses, except for promotion and advertising as allowed in HIM-15;
5. Travel and entertainment, other than for professional meetings and direct operations of home. Costs of motor homes, boats, and other recreational vehicles including operation and maintenance are not allowable expenses;
6. Donations;
7. Expenses of non-ICF/MR's and operations included in expenses;
8. Insurance and/or annuity premiums on the life of the officer or owner;
9. Bad debts, charity, and courtesy allowances;
10. Costs and portions of costs which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;
11. Services provided by the clients' physicians or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state-operated facilities. These exclusions are paid separately;
12. Return on equity;
13. Carry-over of costs "lost" due to any limitation in this system; and
14. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service. Examples include, but are not limited to, swimming pools, tennis courts, handball courts. Recreational and therapeutic facilities necessary for the needs of the mentally retarded in ICF/MR's will be allowed.

31-008.06 Limitations for Rate Determination: The Department applies the following limitations for rate determination to ICF/MRs which are not State-operated.

31-008.06A Expiration or Termination of License or Certification: The Department does not make payment for care provided 30 days after the date of expiration or termination of the provider's license or certificate to operate under NMAP. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's license or certificate to operate under NMAP.

31-008.06B Total Inpatient Days: In computing the provider's allowable cost per day for determination of the prospective rate, total inpatient days are the greater of the actual occupancy or 85 percent of total licensed bed days. Total inpatient days are days on which the patient occupies the bed at midnight or the bed is held for hospital leave or therapeutic home visits. Payment for holding beds for patients in acute hospitals or on therapeutic home visits is permitted if the policy of the facility is to hold beds for private patients and if the patient's bed is actually held. Bedholding is allowed for 15 days per hospitalization and up to 36 days of therapeutic home visits per calendar year for an ICF/MR client.

Medicaid inpatient days are days for which claims (Printout MC-4, "Long Term Care Facility Turnaround Billing Document,") from the provider have been processed by the Department. The Department will not consider days for which a claim has not been processed unless the provider can show justification to the Department's satisfaction. Days for which the client's Medicaid eligibility is in a "spenddown" category are not considered Medicaid inpatient days.

Exception: When a client is admitted to an ICF/MR and dies before midnight on the same day, the Department allows payment for one day of care. The day is counted as one Medicaid inpatient day.

31-008.06C New Construction, Reopenings, and Certification Changes: For new construction (entire facility or bed additions), facility reopenings, or a certification change from Nursing Facility to ICF/MR total inpatient bed days available are the greater of actual occupancy or 50 percent of total licensed bed days available during the first year of operation, beginning with the first day patients are admitted for care.

31-008.06D Start-Up Costs: All new providers entering NMAP after July 31, 1982, shall capitalize and amortize their allowable start-up costs. Only those costs incurred three months before the admission of the first client (private or Medicaid) may be capitalized and amortized. These costs must be documented and submitted with the provider's initial cost report. Amortization of these costs begins on the date of the first admission and must extend over at least 36 months, but must not exceed 60 months.

Start-up costs include, for example, administrative and nursing salaries, heat, gas, electricity, taxes, insurance, interest, employee training costs, repairs and maintenance, housekeeping, and any other allowable costs incidental to the start-up period.

31-008.06E Customary Charge: An ICF/MR's prospective payment for ICF/MR services shall not exceed the ICF/MR's projected average customary charge to the general public for the same level of care services, except for public facilities providing services at a nominal charge. The Department does not use HIM-15, Chapter 26 policies and procedures. Average customary charge is defined as net revenue (total charges for covered services reduced by charity and courtesy allowances, bad debts, and other uncollected charges) derived from "private" residents divided by the "private" inpatient days (including applicable bedholding). The projected average customary charge is computed by adjusting the average customary charge by an amount equal to the lesser of the average customary charge or the allowable operating cost, as computed for the most recent report period, times a percent equal to 1 1/2 times the percent change of the CPI for the year ending September 30 following the end of the most recent report period. Facilities in which private resident days are less than 5 percent of the total inpatient days, as defined in 471 NAC 31-008.06B, will not be subject to the customary charge limitation.

31-008.06F Common Ownership or Control: Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control must not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to the general rule applies if the provider demonstrates by convincing evidence to the Department's satisfaction that -

1. The supplying organization is a bona fide separate organization;
2. A substantial part of the supplying organization's business activity is transacted with others than the provider and organizations related to the supplier by common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;
3. The services, facilities, or supplies are those which commonly are obtained by institutions like the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by similar institutions; and
4. The charge to the provider is in line with the charge for those services, facilities, or supplies in the open market, and is no more than the charges made under comparable circumstances to others by the organization for those services, facilities, or supplies.

When all conditions of this exception are met, the charges by the supplier to the provider for services, facilities, or supplies are allowable as costs.

31-008.06G Leased Facilities: Allowable costs for leased facilities (including, but not limited to, leases, subleases, and other similar types of contractual arrangements), including all personal property covered in the lease, entered into after July 31, 1982, must not exceed the actual cost of the lessor for depreciation, interest on lessor's mortgage, and other costs of ownership incurred as a condition of the lease. If the lessor sells the facility, all provisions of 471 NAC 31-009.06J will apply, except that the Department does not recapture depreciation on leases between unrelated parties. All interest must be specifically identified or reasonably allocated to the asset. All actual costs to the lessor are computed according to the rate setting principles of this section. If costs are claimed for leases, the lease agreement must provide that the lessor will -

1. Provide an itemized statement at the end of each provider's report period which includes depreciation, interest, and other costs incurred as a condition to the lease; and
2. Make records available for audit upon request of the Department, the Department of Health and Human Services (HHS), or their designated representatives.

31-008.06H Interest Expense: For rate periods beginning January 1, 1985, interest cost will not be allowed on loan principal balances which are in excess of 80 percent of the fixed asset cost recognized by the Department for long term care. This limitation does not apply to government owned facilities.

31-008.06J Recognition of Fixed Cost Basis: The fixed cost basis for facilities purchased as an ongoing operation or for newly constructed facilities or facility additions shall be the lesser of -

1. The acquisition cost of the asset to the new owner;
2. The acquisition cost which is approved by the Nebraska Department of Health Certificate of Need process; or
3. For facilities purchased as an ongoing operation on or after December 1, 1984, the allowable cost of the asset to the owner of record as of December 1, 1984, or for assets not in existence as of December 1, 1984, the first owner of record thereafter.

471 NAC 31-008.08D, Recapture of Depreciation, will apply to this part.

Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made are not allowable.

This part will not apply to changes of ownership of assets pursuant to an enforceable agreement entered into before December 1, 1984.

31-008.06K Certificate of Need Approved Projects: Notwithstanding any other provision of 471 NAC 31-008, et seq., the fixed costs reported to the Department of Social Services for a Department of Health Certificate of Need reviewed project shall not exceed the amount that would result from the application of the approved project provisions including the estimated interest rates and asset lives.

Certificate of Need provisions recognized by the Department of Social Services, for the purposes of rate setting, shall be the original project as approved, the approved project amendments submitted within 90 days of the transfer of ownership or opening of newly constructed areas, and the allowable cost overruns disclosed in a final project report submitted to the Department of Health within 180 days of the opening of newly constructed areas. Project amendments and project reports submitted to the Department of Health Certificate of Need after the periods defined above will be recognized upon approval beginning on the date that the amendment or report is received by the Department of Health and Human Services Regulation and Licensure. The added costs incurred prior to the date the late amendment or report is filed will not be recognized retroactively for rate setting.

31-008.06L Salaries of Administrators, Owners, and Directly Related Parties: Compensation received by an administrator, owner, or directly related party is limited to a reasonable amount for the documented services provided in a necessary function. Reasonable value of the documented services rendered by an administrator is determined from Medicare regulations and administrator salary surveys for the Kansas City Region, adjusted for inflation by the Department of Health and Human Services. All compensation received by an Administrator is included in the Administration Cost Category, unless an allocation has prior approval from the Department. Reasonable value of the documented services rendered by an owner or directly related party who hold positions other than administrator is determined by: (1) comparison to salaries paid for comparable position(s) within the specific facility, if applicable, or, if not applicable, then (2) comparison to salaries for comparable position(s) as published by the Nebraska Department of Administrative Services, Division of State Personnel in the "State of Nebraska Salary Survey."

31-008.06M Administration Expense: In computing the provider's allowable cost for determination of the rate, administration expense is limited to no more than 14 percent of the total otherwise allowable Direct Nursing, Direct Support Services, and Other Support Services Components for the facility.

This computation is made by dividing the total allowable Direct Nursing, Direct Support Services, and Other Support Services Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Direct Nursing, Direct Support Services, and Other Support Services components, including the administration cost category. If a facility's actual allowable cost for the three components exceeds this quotient, the excess amount is used to adjust the administration cost category.